(3) For women who, while pregnant, applied for, were eligible for, and received Medicaid services under the plan, all services under the plan that are pregnancy-related for an extended postpartum period. The postpartum period begins on the last day of pregnancy and extends through the end of the month in which the 60-day period following termination of pregnancy ends.

(b) A State plan must specify that eligible aliens as defined in §§435.406(a) and 436.406(a) of this subchapter will receive at least the services provided in paragraph (a) of this section.

(c) A State plan must specify that aliens not defined in §§435.406(a) and 436.406(a) of this subchapter will only be provided the limited services specified in §440.255.

[56 FR 24010, May 28, 1991, as amended at 60 FR 19862, Apr. 21, 1995]

§440.220 Required services for the medically needy.

(a) A State plan that includes the medically needy must specify that the medically needy are provided, as a minimum, the following services:

(1) Prenatal care and delivery services for pregnant women.

(2) Ambulatory services, as defined in the State plan, for:

(i) Individuals under age 18; and

(ii) Groups of individuals entitled to institutional services.

(3) Home health services (§440.70) to any individual entitled to skilled nursing facility services.

(4) If the State plan includes services in an institution for mental diseases (§440.140 or §440.160) or in an intermediate care facility for the mentally retarded (§440.150(c)) for any group of medically needy, either of the following sets of services to each of the medically needy groups:

(i) The services contained in §§440.10 through 440.50 and (to the extent nurse-midwives are authorized to practice under State law or regulation) §440.165; or

(ii) The services contained in any seven of the sections in §§440.10 through 440.165.

(5) For women who, while pregnant, applied for, were eligible as medically needy for, and received Medicaid services under the plan, services under the plan that are pregnancy-related (as defined in §440.210(a)(2)(i) of this subpart) for an extended postpartum period. The postpartum period begins on the last day of pregnancy and extends through the end of the month in which the 60-day period following termination of pregnancy ends.

(b) A State plan must specify that eligible aliens as defined in §§435.406(a) and 436.406(a) of this subchapter will receive at least the services provided in paragraphs (a)(4) (i) and (ii) of this section.

(c) A State plan must specify that aliens defined in §§435.406(b), 435.406(c), 436.406(b) and 436.406(c) of this subchapter will only be provided the limited services specified in §440.255.

[56 FR 24011, May 28, 1991, as amended at 58 FR 4938, Jan. 19, 1993]

§440.225 Optional services.

Any of the services defined in subpart A of this part that are not required under §§440.210 and 440.220 may be furnished under the State plan at the State's option.

[60 FR 19862, Apr. 21, 1995]

§440.230 Sufficiency of amount, duration, and scope.

(a) The plan must specify the amount, duration, and scope of each service that it provides for—

(1) The categorically needy; and

(2) Each covered group of medically needy.

(b) Each service must be sufficient in amount, duration, and scope to reasonably achieve its purpose.

(c) The Medicaid agency may not arbitrarily deny or reduce the amount, duration, or scope of a required service under §§440.210 and 440.220 to an otherwise eligible recipient solely because of the diagnosis, type of illness, or condition.

(d) The agency may place appropriate limits on a service based on such criteria as medical necessity or on utilization control procedures.

[46 FR 47993, Sept. 30, 1981]

§440.240 Comparability of services for groups.

Except as limited in §440.250—

(a) The plan must provide that the services available to any categorically needy recipient under the plan are not less in amount, duration, and scope than those services available to a medically needy recipient; and

(b) The plan must provide that the services available to any individual in the following groups are equal in amount, duration, and scope for all recipients within the group:

(1) The categorically needy.

(2) A covered medically needy group.

[46 FR 47993, Sept. 30, 1981]

§ 440.250 Limits on comparability of services.

(a) Skilled nursing facility services (§ 440.40(a)) may be limited to recipients age 21 or older.

(b) Early and periodic screening, diagnosis, and treatment (§ 440.40(b)) must be limited to recipients under age 21.

(c) Family planning services and supplies must be limited to recipients of childbearing age, including minors who can be considered sexually active and who desire the services and supplies.

(d) If covered under the plan, services to recipients in institutions for mental diseases (§ 440.140) must be limited to those age 65 or older.

(e) If covered under the plan, inpatient psychiatric services (§ 440.160) must be limited to recipients under age 22 as specified in § 441.151(c) of this subchapter.

(f) If Medicare benefits under Part B of title XVIII are made available to recipients through a buy-in agreement or payment of premiums, or part or all of the deductibles, cost sharing or similar charges, they may be limited to recipients who are covered by the agreement or payment.

(g) If services in addition to those offered under the plan are made available under a contract between the agency or political subdivision and an organization providing comprehensive health services, those additional services may be limited to recipients who reside in the geographic area served by the contracting organization and who elect to receive services from it.

(h) Ambulatory services for the medically needy (§ 440.220(a)(2)) may be limited to:

(1) Individuals under age 18; and

(2) Groups of individuals entitled to institutional services.

(i) Services provided under an exception to requirements allowed under § 431.54 may be limited as provided under that exception.

(j) If HCFA has approved a waiver of Medicaid requirements under § 431.55, services may be limited as provided by the waiver.

(k) If the agency has been granted a waiver of the requirements of § 440.240 (Comparability of services) in order to provide for home or community-based services under §§ 440.180 or 440.181, the services provided under the waiver need not be comparable for all individuals within a group.

(l) If the agency imposes cost sharing on recipients in accordance with 447.53, the imposition of cost sharing on an individual who is not exempted by one of the conditions in section 447.53(b) shall not require the State to impose copayments on an individual who is eligible for such exemption.

(m) Eligible legalized aliens who are not in the exempt groups described in §§ 435.406(a) and 436.406(a), and considered categorically needy or medically needy must be furnished only emergency services (as defined in § 440.255), and services for pregnant women as defined in section 1916(a)(2)(B) of the Social Security Act for 5 years from the date the alien is granted lawful temporary resident status.

(n) Aliens who are not lawful permanent residents, permanently residing in the United States under color of law, or granted lawful status under section 245A, 210 or 210A of the Immigration and Nationality Act, who, otherwise meet the eligibility requirements of the State plan (except for receipt of AFDC, SSI or a State Supplementary payment) must be furnished only those services necessary to treat an emergency medical condition of the alien as defined in § 440.255(c).

(o) If the agency makes respiratory care services available under § 440.185, the services need not be made available in equal amount, duration, and scope to any individual not eligible for coverage under that section. However, the services must be made available in equal amount, duration, and scope to